

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9460

CERTIFICATE OF DEATH

09455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>		b. COUNTY <i>Queen Anne's</i>	
c. LENGTH OF STAY IN 1b <i>50 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Ralph Callaway Baynard</i>		First	Middle
4. DATE OF DEATH <i>August 11</i>		Last	Month
		Day	Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 11, 1887</i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM OWNER</i>	
11. BIRTHPLACE (State or foreign country) <i>Farmington, Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Emmett Baynard</i>		14. MOTHER'S MAIDEN NAME <i>Laura Bell Callaway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-964</i>	
17. INFORMANT <i>Riddon E. Baynard, Queenstown, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>430.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Coronary Occlusion</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Centreville MD</i>		20f. (City or town) (County) (State) <i>Centreville MD</i>	
21. I certify that I attended the deceased from <i>July 11, 1958</i> to <i>Aug. 11, 1958</i> , and that death occurred at <i>Centreville MD</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Centreville MD</i>	
ACTUAL SIGNATURE <i>H. F. McPherson</i>		DATE SIGNED <i>Aug. 15, 1958</i>	
PHYSICIAN'S NAME (Type) <i>H. F. McPherson</i>			
22a. BURIAL, Cremation, Removal (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 14, 1958</i>	
22c. NAME OF CEMETERY OR Crematory <i>Chesterfield Cemetery</i>		22d. LOCATION (City, town or county) <i>Centreville Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Bentz Jr. of Bentz Bros., Centreville, Maryland</i>		24a. REG'D BY REGISTRAR DATE AUG 15 '58	
ADDRESS <i>Centreville MD</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09456

9461

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CHURCH Hill		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CHURCH Hill	
d. STREET ADDRESS _____		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VAN First GASKEN Middle CLARK Sr. Last		4. DATE OF DEATH Month Day Year AUG. 1 1958	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 27-1902	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OLIVER CLARK		14. MOTHER'S MAIDEN NAME SALLY DULIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT Mrs. Van Clark Church Hill Md.		Address Coronary Occlusion	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 			
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1st , 1958, to Aug 1st , 1958, that I last saw the deceased alive on Aug 1st , 1958, and that death occurred at 6 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H.F. McPerson		ADDRESS (Street, city or town, state) Centerville Md. DATE SIGNED 8/21/58	
PHYSICIAN'S NAME (Type) H.F. McPerson			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 4	
22c. NAME OF CEMETERY OR CREMATORIAL Chesterville		22d. LOCATION (City, town, or county) Centerville Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane		ADDRESS Church Hill Md.	
24a. REC'D BY REGISTRAR DATE Aug 6 '58		24b. REGISTRAR'S SIGNATURE Reed	

WATERPOWER CERTIFICATE OF REGISTRATION

CERTIFICATE OF DESIGN

Design No.

Date of Registration

Expiry Date

Period of Registration

Period of Validity

Design No.

Date of Registration

Expiry Date

Period of Registration

Period of Validity

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	c. LENGTH OF STAY IN 1b <i>All life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <i>Howard Embert Cook</i>	First	Middle	Last	4. DATE OF DEATH <i>August 31, 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct. 14 1895</i>	9. AGE (In years last birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm owner</i>	11. BIRTHPLACE (State or foreign country) <i>Rural Centreville, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>William Thomas Cook</i>	14. MOTHER'S MAIDEN NAME <i>Mary V. Embert</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-36-0324</i>	17. INFORMANT <i>William H. Cook, Centreville, Maryland</i>	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Found dead in kitchen & bed</i>	
434.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) <i>been dead for 6 days — He had had</i>
	DUE TO (c) <i>heart disease & short winded for some time</i>

MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .

ACTUAL SIGNATURE <i>W. Henry Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9/5-58</i>
EXAMINER'S NAME (Type) <i>W. Henry Fisher</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Sept. 6, 1958</i>	22c. NAME OF CEMETERY, OR CREMATORIAL <i>Chesterfield Cemetery</i>	22d. LOCATION (City, town, or county) <i>Centreville, Maryland</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Beatty, Jr., of Beatty Bros., Centreville, Maryland</i>	ADDRESS <i>ADDRESS</i>	24a. REC'D. BY REGISTRAR <i>REC'D. 8 1958</i>	24b. REGISTRAR'S SIGNATURE <i>John H. Beatty</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 or 2 with the registrar prior to burial, cremation, or removal.

V.S. ATSMES(5)
 5M 9/5/58

WILDCAT-GUNNISON, COLORADO-OCEAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9463

CERTIFICATE OF DEATH

09458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton		c. LENGTH OF STAY IN lb		X Crumpton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle C.	Last DIXON	4. DATE OF DEATH August	Month 9	Day 1958	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January, 24, 1891	9. AGE (In years (at birthday) 67 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dixon		14. MOTHER'S MAIDEN NAME Anna Shahan					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-28-2197A		17. INFORMANT Mrs. Myrtle Dixon,		Address Crumpton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) (c)		Hypertension - Arteriosclerosis		3 years - 4-5 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Doy Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MILLINGTON, MD	(County) Kent Co.	(State) Md.
21. I certify that I attended the deceased from Nov 9, 1955 to Aug 9, 1958 , that I last saw the deceased alive on Aug 6, 1958 , and that death occurred at 74 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Gra Knobleske</i>	M.D.		ADDRESS (Street, city or town, state) MILLINGTON, MD		DATE SIGNED 8.10.58		
PHYSICIAN'S NAME (Type) GEO KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 13, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Millington Cem.	22d. LOCATION (City, town, or county) Millington, Kent Co. Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Millington, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DAUG 14 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knobleske</i>				

IT IS NOT THE HUMAN SOCIETY WHICH IS DESTROYED.
IT IS THE SOCIETY WHICH DESTROYS HUMANS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09459

9464

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Queen Anne's MARYLAND		a. STATE Maryland b. COUNTY Queen Anne's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Rural Stevensville	2 yrs.	x Rural Stevensville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
R. Mildred Mitchell				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
4. DATE OF DEATH	Month	Day	Year	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 10, 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
REGISTERED NURSE	Retired	Queenstown, Maryland	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
Charles Joseph Brown Mitchell	Georgia Emory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
No	NONE	C. Mitchell Davidson, Stevensville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinoma of r. breast about 2 years ago			
170X				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	Metastases generalized in chest & abdomen 1 year		
	(c)	cholecystectomy 8 years ago		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
Mastectomy of breast Aug. 1957				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
39				
21. I certify that I attended the deceased from Aug. 12, 1958, to Aug. 13, 1958, that I last saw the deceased alive on Aug. 12, 1958, and that death occurred at 11:45 P.M., from the causes and on the date stated above.				
ACTUAL SIGNATURE Theodor Sattelmayer, M.D. STEVENSVILLE, MD.				ADDRESS (Street, city or town, state) DATE SIGNED Theodor SATTELMAIER, M.D. STEVENSVILLE, MD. Aug. 14, 1958
PHYSICIAN'S NAME (Type)		22a. BURIAL, Cremation, Removal (Specify) 22b. DATE THEREOF		
Burial		Aug. 16, 1958		
23. FUNERAL DIRECTOR'S SIGNATURE		22c. NAME OF CEMETERY OR Crematory	22d. LOCATION (City, town, or county) (State)	
John H. Beatty, Jr., of Baltimore, Maryland		Old Wye Church	Wye Mills, Maryland	
ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
		DATE AUG 18 '58		Arthur S. Trahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of this certificate and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after the death certificate is filed.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9465

CERTIFICATE OF DEATH

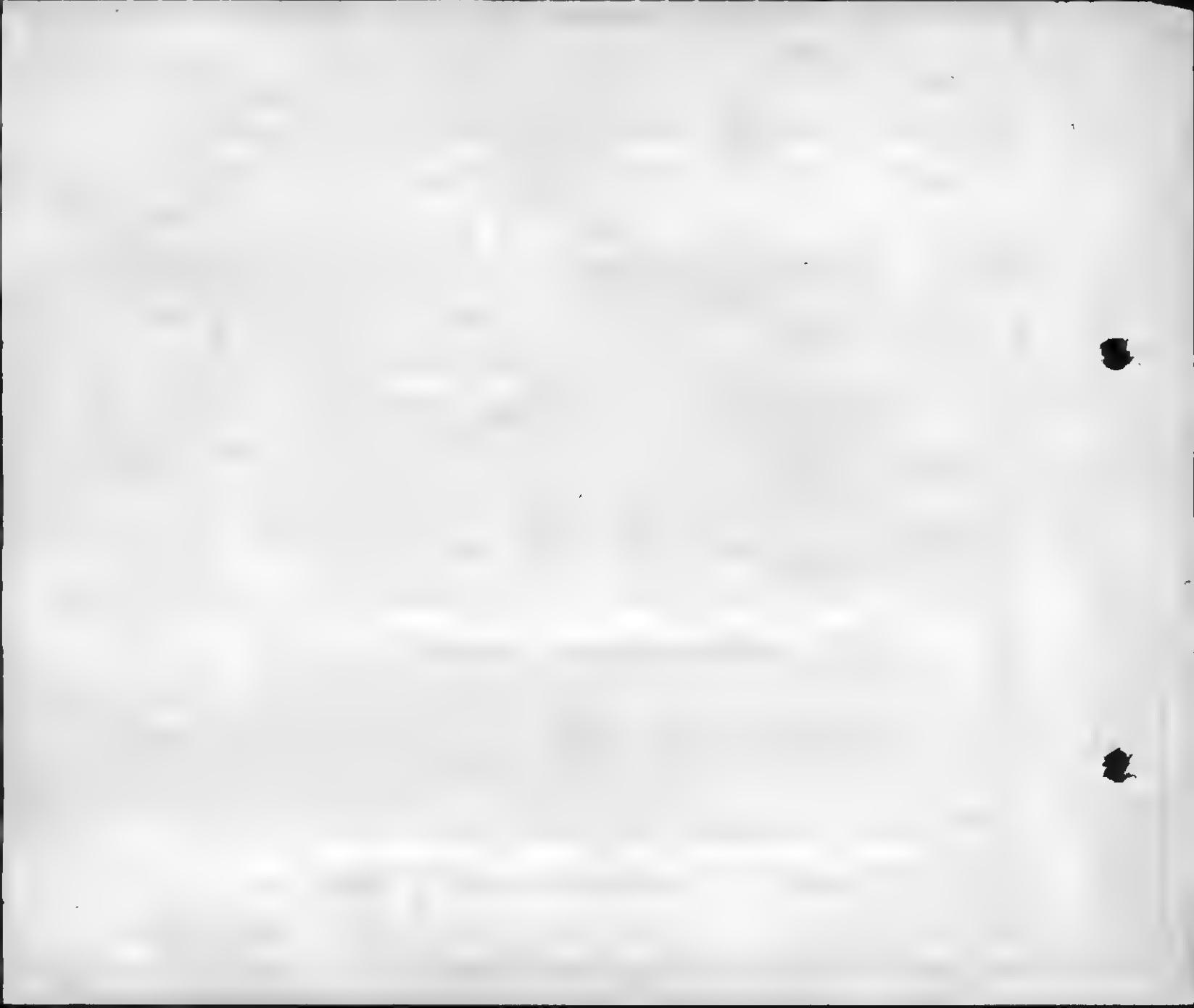
Reg. Dist. No.

69460

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Stevensville</i>		c. LENGTH OF STAY IN 1b <i>8 yr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Stevensville</i>	
3. NAME OF DECEASED (Type or print) <i>Frank</i>		d. STREET ADDRESS <i>—</i>	
4. DATE OF DEATH <i>August 3</i>	Month	Day	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 15, 1897</i>
9. AGE (In years last birthday) <i>61</i>	yrs.	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dentistry</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Novak</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hajek</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Dona Novak</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>8 mo.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>51</i> , to <i>Aug 4</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Aug 2</i> , 19 <i>58</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irvin G. Hoyt</i> PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt</i>		ADDRESS (Street, city or town, state) <i>Oxon Town, Md.</i> DATE SIGNED <i>8/3/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 5</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Stevensville</i>	22d. LOCATION (City, town, or county) <i>Stevensville, Ind.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar S. Lane</i>	ADDRESS <i>Church Hill</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 6 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alt. edieh</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

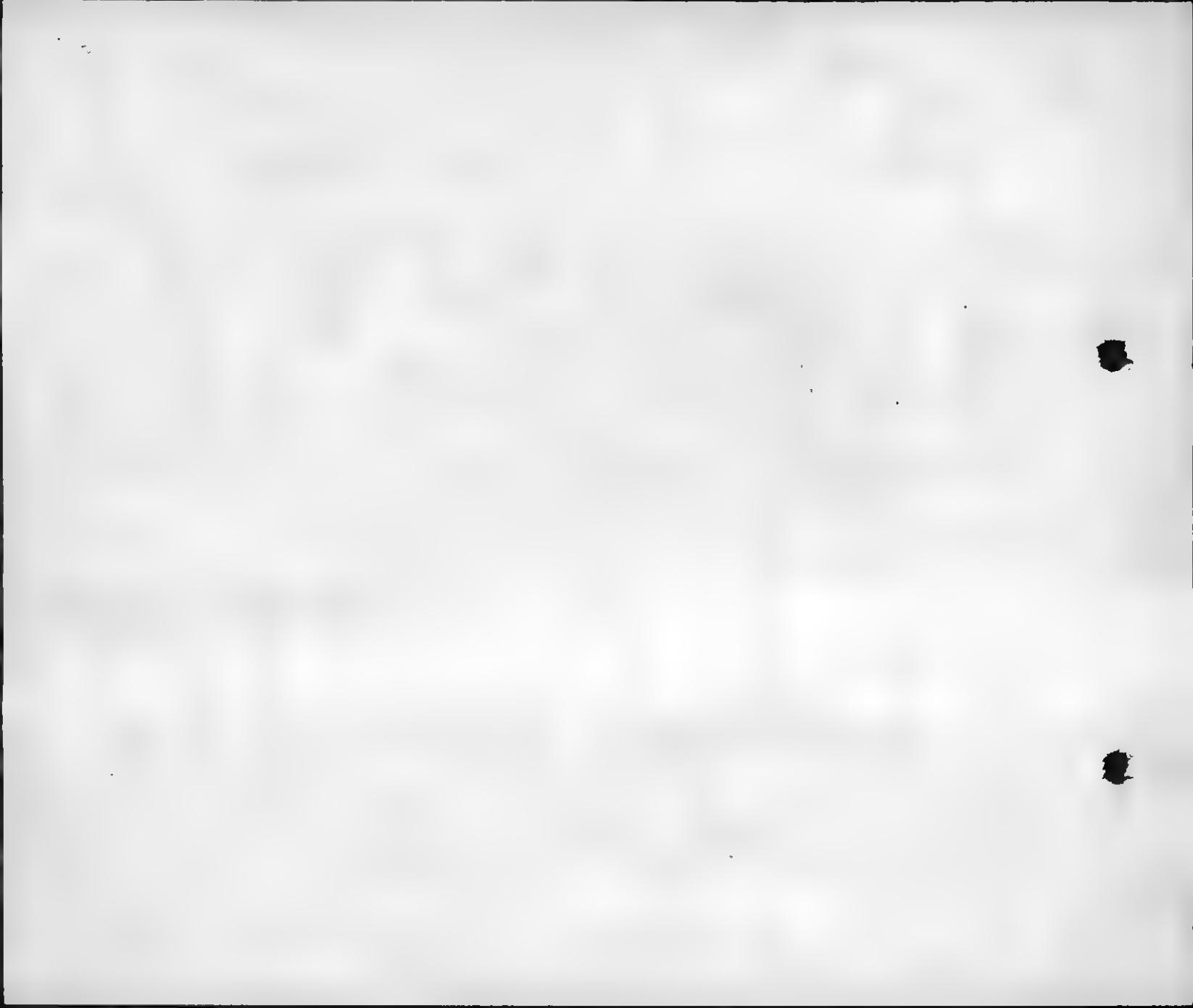
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deleted for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 09461						
1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S b. CITY OR TOWN (if outside corporate limits, write RURAL) Centreville				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Centreville														
c. LENGTH OF STAY IN 1b 6 weeks				d. STREET ADDRESS 				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Norman				First	Middle	Last	4. DATE OF DEATH August 28, 1958				Month	Day	Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 16, 1910		9. AGE (in years last birthday) 48 yrs.		10. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			11. BIRTHPLACE (State or foreign country) Mount Vernon, Illinois			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not regular) CLERK - BOOKKEEPER Equipment Co.				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION				11. BIRTHPLACE (State or foreign country) Mount Vernon, Illinois				12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME John Griffith Pate				14. MOTHER'S MAIDEN NAME MARY Emma McCLEAN														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service) YES WW II				16. SOCIAL SECURITY NO. 346-07-1721				17. INFORMANT Mrs Lola Pate - wife. Centreville, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion																		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)																		
DUE TO (c)																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>																		
ACTUAL SIGNATURE W. Henry Fisher												DATE SIGNED 8/30/58						
EXAMINER'S NAME (Type) W. Henry Fisher												M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 1958				22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cemetery				22d. LOCATION (City, town, or county) Centreville, Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE James H. Bentz Jr. of Bentz Bros. Centreville, Md.				24a. REC'D BY REGISTRAR SEP 3 '58				24b. REGISTRAR'S SIGNATURE Charles S. Kraus										



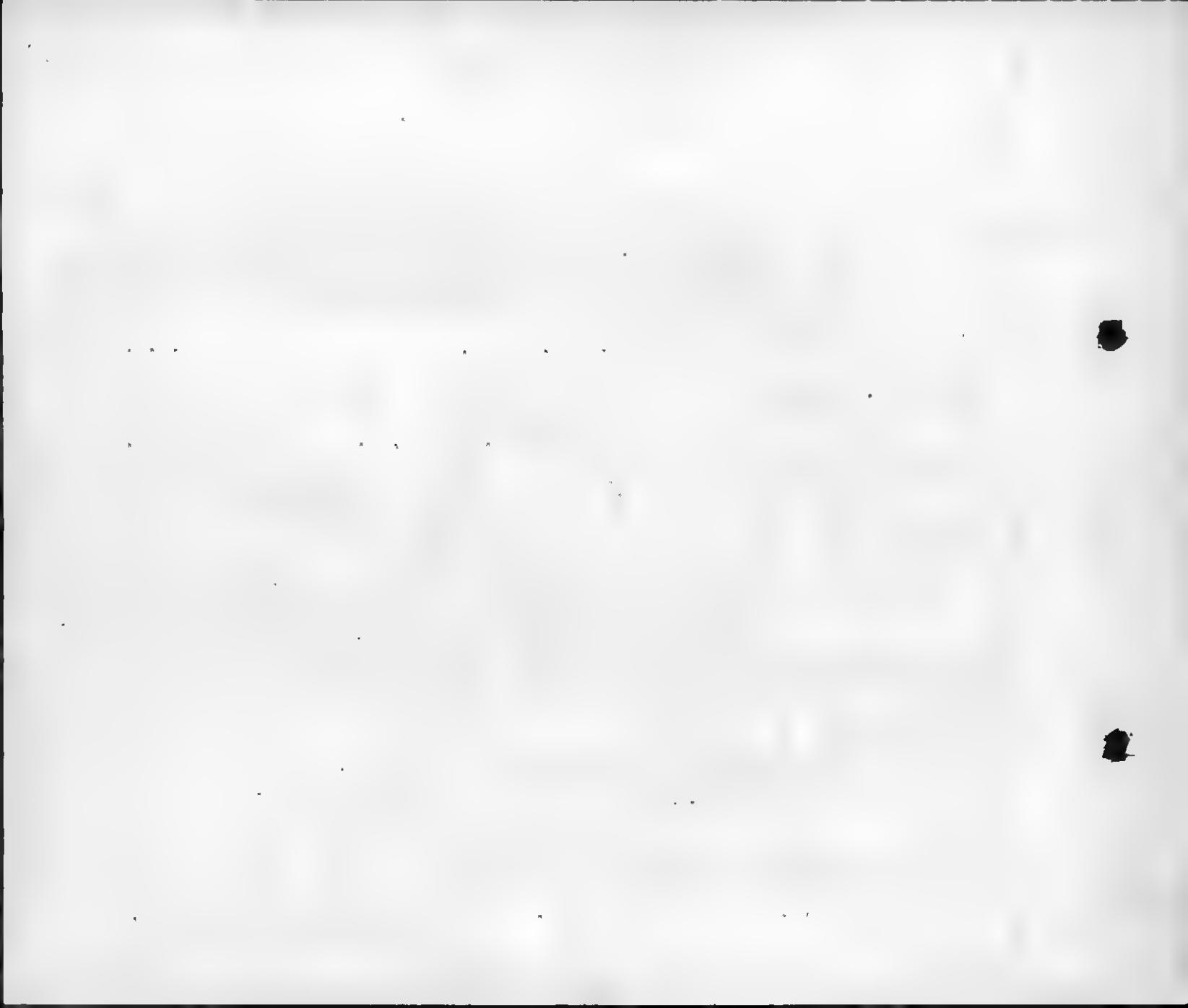
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9467

CERTIFICATE OF DEATH

Reg. Dist. No. 09462

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Rural Millington		c. LENGTH OF STAY IN 1b Rural Millington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAVID	Middle F.	Last WADDELL SR.	4. DATE OF DEATH	Month August	Day 30	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH May 18, 1892	9. AGE (in years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired Ref. Eng.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles G. Waddell			14. MOTHER'S MAIDEN NAME Martha Standard						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 148-01-922		17. INFORMANT David F. Waddell, Jr.		Address Millington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dr. Charles G. Waddell Edward G. Fellows Arthur S. Kiana						INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car accident						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crumpton, Cem.		20f. (City or town) Crumpton		(County) None	(State) Md.
21. I certify that I attended the deceased from Aug 29, 1958 , to Aug 30, 1958 , that I last saw the deceased alive on Aug 29, 1958 , and that death occurred at 3 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) None DATE SIGNED Sept. 1, 1958 Arthur S. Kiana									
ACTUAL SIGNATURE David F. Waddell		PHYSICIAN'S NAME (Type) Edward G. Fellows							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Crumpton, Cem.		22d. LOCATION (City, town, or county) Crumpton		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward G. Fellows		ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial. Cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9468

Reg. Dist. No.

09463

1. PLACE OF DEATH a. COUNTY QUEEN ANNE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY QUEEN ANNE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PONDTON - RURAL		d. STREET ADDRESS CHESTERTOWN				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First JOHN	Middle	Lost WASHINGTON	4. DATE OF DEATH Month AUGUST	Day 11	Year 1958			
5. SEX M.		6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 11 1882	9. AGE (in years lost birthday) yrs. 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME GEORGE WASHINGTON		14. MOTHER'S MAIDEN NAME UNKNOWN								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT NONE EMMA WASHINGTON, CHESTERTOWN		Address RURAL MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease		DUE TO 420.0		INTERVAL BETWEEN ONSET AND DEATH Unknown						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. None		(b) Gen. Arterio Sclerosis		Several years						
		(c) Cardiac Asthma		3 weeks						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m.		20d. INJURY OCCURRED While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County) None	(State) None	
21. I certify that I attended the deceased from Aug 2 , 1958 to Aug 11 , 1958 that I last saw the deceased alive on Aug 2 , 1958, and that death occurred at 5:30 PM , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) M.D. Millington Md.		DATE SIGNED 8/13/58
ACTUAL SIGNATURE H.H. Hamilton		M.D.								
PHYSICIAN'S NAME (Type) H. H. HAMILTON										
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/14/58		22c. NAME OF CEMETERY OR CREMATORIUM BETHEL Cen.		22d. LOCATION (City, town, or county) PONDTON		(State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Lewis, Millington, Md.		ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR JULY 15 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Knapp				

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	TIME OF DEATH	PLACE OF DEATH
John Doe	55	M	Heart Disease	10:00 AM	Hospital
ADDRESS OF DECEASED					
123 Main Street, Anytown, USA					
NAME AND ADDRESS OF PHYSICIAN					
Dr. John Smith, 456 Elm Street, Anytown, USA					
NAME AND ADDRESS OF FUNERAL DIRECTOR					
John Doe Funeral Home, 789 Oak Street, Anytown, USA					
DATE OF DEATH					
May 15, 2023					
SIGNATURE OF REPORTER					
John Doe, M.D.					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9469

CERTIFICATE OF DEATH

Reg. Dist. No.

09464

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>	
3. NAME OF DECEASED (Type or print) <i>Bru Burton</i>		First <i>Bru</i>	Middle <i>Burton</i>
4. DATE OF DEATH Month <i>8</i>		Day <i>30</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/10/78</i>
9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Oystering</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Mary Ellen Wilson</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>XX - XX</i>	16. SOCIAL SECURITY NO. [If yes, give war or dates of service]	17. INFORMANT <i>Mrs. Carrie Marney, Chester Md.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Carcinoma of the stomach	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1958</i> to <i>Aug 1958</i> , that I last saw the deceased alive on <i>Aug 25 1958</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irvin G. Hoyt</i> M.D. ADDRESS (Street, city or town, state) <i>Glenelg, Md</i> DATE SIGNED <i>9/2/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/3/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chestertown</i>	22d. LOCATION (City, town, or county) <i>Chestertown</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daniels, Easton Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>SEP 3 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Knaus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then, please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE AT DEATH	CAUSE OF DEATH	
MR. JAMES H. COOPER	65	HEART DISEASE	
ADDRESS	STREET	CITY	
1234 FAIRFIELD DR.	FAIRFIELD	NEW YORK	
NAME OF DOCTOR	ADDRESS	STREET	CITY
DR. RICHARD M. COOPER	1234 FAIRFIELD DR.	FAIRFIELD	NEW YORK
NAME OF FUNERAL DIRECTOR	ADDRESS	STREET	CITY
MR. JOHN H. COOPER	1234 FAIRFIELD DR.	FAIRFIELD	NEW YORK
DATE OF DEATH	TIME OF DEATH	REMARKS	
MAR 12, 1985	10:00 AM		
TIME OF AUTOPSY	REMARKS		